



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ROSHAN L SHARMA MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-1404--01

Carrier's Austin Representative

BOX NUMBER: 54

MFDR Date Received

JANUARY 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual Insurance Company has denied this claim many times for various reasons; such as information doesn't support this level of service, time limits have expired, and the final denial was that the information submitted didn't support the service level. All documentation that was sent to them after the initial submission was corrected to better support CPT code 99214, yet they still denied the claim for payment... We feel that we have met all of Texas Mutual Insurance Companies denial requests, but each time we do they are not satisfied with what we submit."

Amount in Dispute: \$120.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provide E/M services on the date above then billed Texas Mutual code 99214 for this. Texas Mutual has consistently denied payment absent documentation support the use of the code. By that Texas Mutual means the documented History is complete for code 99212 but not 99214. There is no Review of Systems. The Exam concentrates on one body area, the low back, and represents a problem-focused exam. The CPT criteria for code 99214 identifies two of three key components must be met to qualify 99214. The three components are a Detailed History, Detailed Exam and Moderate Complexity of Medical Decision Making. With an incomplete History and a problem-focused exam, the E/M documentation does not support the billing of code 99214."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 24, 2013	CPT Code 99214	\$165.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or

- after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for E/M services

The services in dispute were reduced/denied by the respondent with the following reason codes:

- 150 – Payer deems the information submitted does not support this level of service.
- 890 – Denied per AMA CPT Code Description for level of service and/or nature of presenting problems.
- W3, 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 16 – Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason code.)
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 891 – No additional payment after reconsideration.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, “for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...” Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient. The American Medical Association (AMA) CPT code description for 99214 is:

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

The 1997 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare policy. It describes the documentation requirements for the service in dispute. Review of the documentation finds the following:

- Documentation of the Detailed History
 - History of Present Illness (HPI) consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions. Documentation found listed one chronic condition, low back, thus, this component was not met.
 - Review of Systems (ROS) requires two to nine systems to be documented. Documentation found listed one system, musculoskeletal, this component was not met.
 - Past Family, and/or Social History (PFSH) requires at least one specific item from any three history areas to be documented. The documentation found listed one area, family history. This component was met.
- Documentation of a Detailed Examination:
 - Requires extended exam of affected area(s) and other symptomatic or related organ system(s), additional systems up to total of seven systems to be documented. The documentation found listed one body area/organ system, low back and musculoskeletal). This component was not met.

2. For the reasons stated above, the division concludes that the documentation does not sufficiently support the level of service billed.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 31, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.